PRESIDENTIAL ADDRESS

From the Society for Clinical Vascular Surgery

Canine or chameleon (revisited): A never-ending challenge in a perpetually changing world

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As I expect it is with all who have held this position, the days leading up to this moment have been rife with tension. Life becomes all about this thing we call the Presidential Address. Over the course of my career I've given hundreds of "talks," but the focus there was always to be informative or educational. Somehow, today I'm supposed to be more than just that; today I'm supposed to be meaningful. I'm supposed to say something or do something that confirms that I was a good choice for this role or, better yet, that makes it worth your while to have come to hear me today. And to be truly meaningful, I'm supposed to impart some knowledge or initiate some change that has an effect on your lives. While you may or may not expect this of me, I expect it of myself, and have searched for ways to make a meaningful contribution to this esteemed organization you have entrusted me to lead for the past year and shape in the years to come. I have decided to focus my thoughts today on what I consider to be 1 of the 3 cornerstones of success of any organization.

The way I see it, there are 3 principal conditions that must be met for an organization to thrive and remain vital. First and foremost, the organization and the people who make it up must have a unique identity, a common focus or cause, a reason to come together for camaraderie and betterment of the group. The root of these "connections" we have to each other were well described in Dr Webster's Presidential Address to this organization in 2001.[1] He expounded on the uniqueness of our specialty, the natural divergent evolution of general surgery and vascular surgery from their common parent of the past, and the virtues of pursuing an independent American Board for Vascular Surgery (ABVS). You would be wise to reread his address, as I have in preparation for my own, because it is as insightful and relevant today as it was 3 years ago, and the underlying ABVS issue, as you shall hear, remains unresolved.

The second cornerstone of success has been covered by Enrico Ascher, and that is the need for a society to have a mechanism for reproducing ourselves. In last year's Presidential Address[2] Dr Ascher proposed a long-overdue overhaul of our vascular surgery training paradigm, one that trains the vascular surgeon of tomorrow more comprehensively and efficiently than we do today. We have evolved dramatically over the past decade, so it is natural that how we make more of ourselves should also evolve. While both of these issues—our unique identity and a new training paradigm—remain relevant and poignant today, what more could I possibly add to the visions of these 2 past presidents for the changes needed in these respective aspects of our profession?

The last cornerstone, and the one I wish to concentrate on today, is the cornerstone that represents how we function as a group, how we govern ourselves, which determines how our members relate within the organization and how we respond to changing times. For any group to remain prosperous there has to be a mechanism of government, which includes but is not limited to leadership. Leaders are the persons in office or other positions of influence who often serve to channel the direction of the group toward some perceived beneficial goal. Government, on the other hand, is the process established to provide equal opportunity for members to have input into that goal and participate in the process of achieving it. When both are in balance the group as a whole is best able to adapt to the changing world around them. After much consideration, then, I have decided to focus my address today on the lessons I have learned in the pursuit of my generation's principal challenge, the endovascular revolution, in the hope that by identifying and correcting the factors that prevented vascular surgery from responding and adapting better to this issue we can do better the next time around.

Before I proceed, let me take a moment to assure you that my intent is to be, as Alan Lumsden has termed it, "presidential." Though in my past some have thought my statements and actions irreverent, more often than not that irreverence was nothing more than the simple act of dis-

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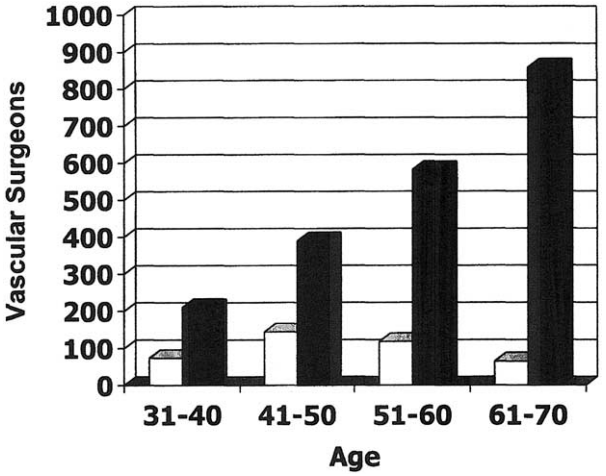

Fig 1. Endovascular competency. Number of vascular surgeons in North America with *(white columns)* and without *(black columns)* comprehensive endovascular competence.

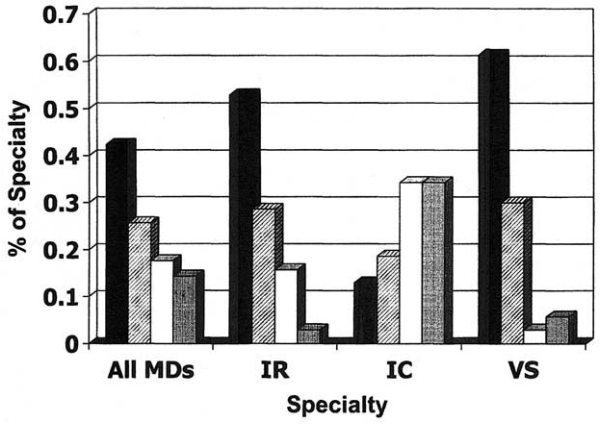

Fig 2. Embolic protection experience. Proportion of all physicians *(All MDs)*, interventional radiologists *(IR)*, interventional cardiologists *(IC)*, and vascular surgeons *(VS)* with no experience *(black columns)*, low experience *(light gray columns)*, moderate experience *(white columns)*, and high experience *(dark gray columns)* with embolic protection devices.

agreeing with someone who got into this sandbox and made their contributions before I did. So while there is no intent to be irreverent here today, it would not be presidential of me to compromise my constituency by not identifying situations I perceive to be in need of correction. Nor is it disrespectful to examine the direction our specialty is taking, to question whether the methods of the past are appropriate for the vascular surgeon of today and particularly of the future, and to seek to provide leadership in areas of personal conviction. After all, I have never known an organization that I didn't think could be improved, and if it were an organization I valued, that I didn't want to be a part of making that happen.

CANINE OR CHAMELEON?

I am perhaps best defined as an endovascular education enthusiast, primarily because of my steadfast belief that endovascular skills should be part of who we are and my efforts to make that happen. In 1993, in the now defunct journal *Vascular Forum*, I published my first "Canine or Chameleon" manuscript, detailing my fledgling experience with incorporating comprehensive, for those times at least, endovascular procedures into my vascular surgery practice, and encouraged other vascular surgeons to do the same.[3] Now, getting this published was no great academic feat. After all, it was a struggling journal in pursuit of manuscripts. But it serves for me as a mile marker on my endovascular journey and my pursuit to make that opportunity available for all vascular surgeons. A decade later, I suspect many of you would say that vascular surgery had successfully surmounted the endovascular challenge, that we live in a terrarium of chameleons, not a junkyard full of howling dogs. After all, by now most vascular surgeons are at least participating in aortic endografting, a variety of postgraduate endovascular training opportunities are available, and we have required minimums for endovascular case volumes in our fellowship programs.

Recent data collected by Dick Green, however, tell a very different story (R. M. Green, personal communication, February 2004). When evaluated from the standpoint of comprehensive endovascular competency, the skill level needed to be competitive in today's marketplace, failure of the old dogs to learn these new tricks is immediately apparent. Even worse, though, this slide (Fig 1), graciously provided to me by Dr Green, reveals that in even our youngest group only about one third are deemed truly endovascular-competent. And this is our best showing! The clear majority of vascular surgeons in all age groups practice at the relatively rudimentary aortic endograft level, and many senior surgeons are not bothering to pursue these skills at all. Sadly, the situation may not be improving very quickly, based on the 2002 data provided by applicants to the American Board of Surgery (ABS) qualifying examination in vascular surgery. Only 43 of 98 applicants, a mere 44%, met the Society for Vascular Surgery (SVS) recommended endovascular credentialing minimums for interventions, and those were primarily based on aortic endograft procedures. Catheterization experience lagged even farther behind, and few vascular fellows received the comprehensive broad-based endovascular training actually called for in our credentialing standards.

Furthermore, when considering experience with antiembolic protection devices, undeniably a necessary skill to possess to be competitive in the upcoming carotid angioplasty melee, the proportion of vascular surgeons with little or no experience exceeds that of all other specialties (Fig 2). So clearly I would have to say that, though we may not have absolutely failed in our mission to convert canines to chameleons, we are still a long way from our goal, and it has taken far too long to achieve even what we have, time that has allowed our competition to cut deep inroads into our traditional domain. Why have we as a group responded so

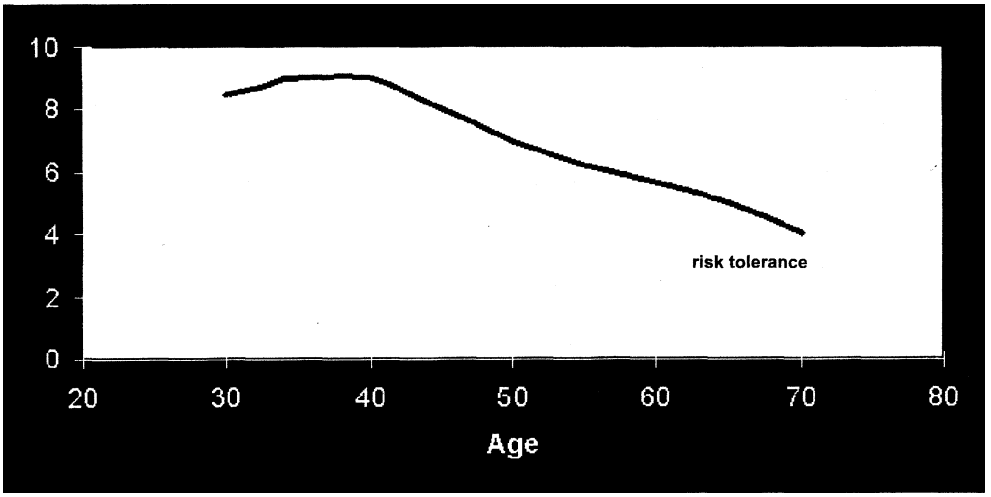

Fig 3. Risk tolerance by age. Characterization of relationship between age and risk tolerance.

poorly to what was actually a simple evolution for some of us, not even the revolution that so many proclaim, implying that it came on way too quickly to have reacted any faster? And how can we learn from this lesson of our past so that we are better positioned to adapt to future change?

LESSONS LEARNED IN MY ENDOVASCULAR LIFE

My experience promoting endovascular training provides several interesting examples of different ways persons and organizations respond to changing times. In 1995, at the annual meeting of this organization in Fort Lauderdale, I presented our experience with incorporation of endovascular training into our vascular surgery fellowship program.[4] It was published in the *American Journal of Surgery* in August of that year, and stimulated your then president, Bruce Brenner, to add an endovascular workshop to the following year's Society for Clinical Vascular Surgery (SCVS) meeting. Sounds great, but that was not the typical reaction to my pleas. The SVS meeting was held in New Orleans that year, and featured an evolving technologies issues session and panel discussion, all of which, of course, were about endovascular trends. I made a plea to the panel for incorporation of endovascular training into vascular fellowship programs, a plea that was largely dismissed by the panel as being unrealistic. After all, we're surgeons, not catheter jockeys, I was told. I remember walking away knowing I was right, and wondering how long it would be before our leaders figured it out. Later, at an Association of Program Directors in Vascular Surgery meeting in 1997, during the reign of a now deceased president, I was told, "Sit down; we're not going to be talking about that," when I raised the issue again. No one protested, no one questioned, everyone just went about their business. So for years we did nothing to adapt to the changing world around us, despite pleas to the contrary from the handful of enlightened. All the while, technology advanced, and when there were not enough endovascular-competent vascular surgeons capable of delivering that technology to meet the needs, nature did what nature always does: it acts to fill the vacuum, in this case with others purporting to be specialists in these diseases.

But there was no stopping the endovascular train, and in time opportunities to promote the endovascular cause and influence the direction of our specialty came about, largely through appointments to the SVS Endovascular Issues Committee. I remember being quite surprised at my first meeting to see how little confidence more senior members had in vascular surgeons being able to become skilled enough to practice comprehensive endovascular therapy without an alliance with interventional radiology. This was a big issue at the time, because an SVS/Society of Cardiovascular and Interventional Radiology collaboration document was in final draft, one that I and several others thought would be damaging to vascular surgery because it promoted the concept of a need to collaborate in order to provide adequate care. Clearly, our representatives' uncertainty about the skills required for endovascular procedures put them in a weak negotiating position. In retrospect, several of the more senior vascular surgery members who had been working on that document, which they thought at the time was good for vascular surgery, have confided to me that they now believe that if it weren't a case of the wrong people being at the table representing vascular surgery, then at least not all of the right people had been either. The right people, in this case, were those who were actively involved in endovascular technology. In the end, the objections raised were effective in derailing the document, so no damage was done. Clearly, however, at least part of the problem, as I see it, was that vascular surgeons who had a different view of our specialty's future had not been empowered to effectively promote their agenda within our governance system during the early stages of the document, when a document of value to vascular surgery

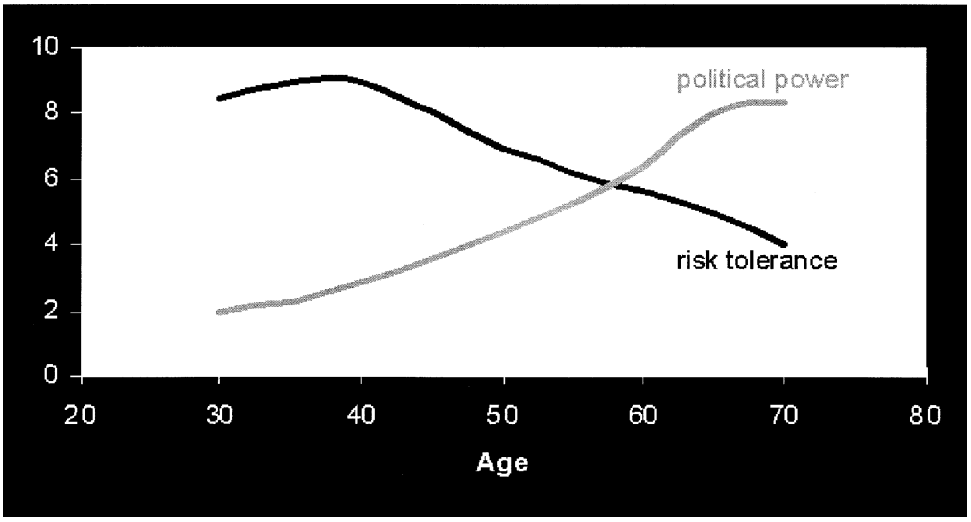

Fig 4. Risk tolerance versus political power. Characterization of relationship between age and ability to influence the direction of one's specialty.

might have been produced. Our specialty had lost the benefit of the experience and youthful exuberance of our junior members.

Viewed graphically, I have depicted here my generalization of people's attitude toward change— let's call it risk tolerance—as a function of age (Fig 3). Though not always the case, openness to change, and in fact enthusiasm for change, is something that naturally diminishes with age. Willingness to try new things, to stick one's neck out, and to endure the sometimes painful outcomes are characteristics of youth, or as some might say, inexperience. I see the trend in myself, and I'm hardly long in the tooth. Yet these are the very characteristics that we require to move ourselves forward as a specialty. If I now overlay onto this graph my generalization of a person's ability to influence our specialty's direction as a function of age, other than through publication (Fig 4), it is apparent that we are underutilizing the talents of our youth, and that for our maintained vitality as a specialty and a society we need to think like chameleons once again. We need to change the way we do business with ourselves, embrace all of our various resources, and encourage active participation in our efforts and direction, not to replace the wisdom of experience, but to complement it for the betterment of all.

RESPONDING TO A CHANGING WORLD

Most medical societies in existence today were born in an era when their primary purpose was advancement of the specialty through the sharing of scientific works, usually performed in single institutions using techniques that any surgeon could use. These were initially small collegial groups where, other than presiding over annual gatherings to exchange information, there were few other missions. Today's societies are a very different animal. Today our members call on their societies to not only keep them intellectually current but to provide training opportunities for the changing technical skill sets required to be competitive in today's world. They want their societies to champion malpractice reform and better reimbursement, write credentialing recommendations and position statements, and initiate improved training paradigms and public awareness campaigns. These efforts are best achieved by a large group, in part by virtue of the extra political clout size typically affords, but also to keep us collectively heading in the right direction through broad-based insight. These efforts require us to reach out to the next generation of vascular surgeons, in whatever form that may take, and involve them in determining their destiny.

This year's SCVS meeting is a first step in my goal for that kind of change within this society. One of the more relaxed and openly collegial of societies from the get-go, the SCVS has gone all-out this year, with generous support from the vascular industry, to provide opportunities for vascular fellows to attend and participate in our meeting. You no doubt observed in the earlier sessions that we invited vascular fellows to open the discussion of an assigned abstract. Often the most stimulating aspect of a paper is not the questions it answers, but the questions it raises, and we are looking forward to fresh and stimulating questions from our fellows and soon-to-be colleagues. Furthermore, with additional industry participation we have been able to offer vascular fellows and other registrants the opportunity to experience the next generation of endovascular training methods, the endovascular simulator. These devices figure to have a prominent role in training vascular surgeons in carotid angioplasty techniques, and offer the potential to shorten both the learning and credentialing curves for endovascular procedures overall. The ability of the society to offer these experiences stems from yet other changes in the world around us, those related to how industry introduces new products into clinical practice and

supports physician education in times when the perception of impropriety pervades industry-physician interaction.

No doubt you have heard about one such change, the AdvaMed guidelines. These are the voluntary guidelines recently created and enacted by the medical device industry to reign in activities that could be perceived as inappropriately influencing physician judgment. While many resent yet additional regulations intruding in our lives, these guidelines offer opportunities for those able to adapt to this change, and changes in this meeting have set us on a course to do just that. Meetings such as our own and virtually all others simply could not happen without the support of industrial sponsors. Long-time supporters of physician education, understandably with multiple motives, not the least of which is profit, industry has an ongoing incentive to contribute to physician education and its own role to play in moving our discipline forward. The new restrictions on how industry participates in this process offers us an opportunity to partner with them to help deliver the desired educational product in an educationally sound and unbiased manner. This adds to the content and value of what we can offer at our annual meeting, and our members are the direct beneficiaries. We have already begun to explore even greater educational opportunities for next year's meeting.

LOOKING IN THE MIRROR

This brings me to the last element of change I have proposed for this society this year, one that I hope will set an example for others as well. The stories of the obstacles I faced in promoting an endovascular education agenda don't do justice to the frustration and disenfranchisement I and others felt about our inability to effect change in the direction of our specialty. Similar frustration at last year's SVS meeting led some to attempt an embarrassing floor challenge to the Nominating Committee's recommendation for president, which was contentious inasmuch as no consensus candidate had emerged. While a discussion of the wisdom and merits of that challenge are for another time, what struck me most about that experience was that there truly ought to be some respectable mechanism for the membership to have bona fide choice in the selection of their leadership. The role of our societies in promoting the very health and vitality of our specialty has moved us beyond the more honorary role of leadership of the past. Just as we need and expect more from our societies today, we need more from our leaders as well; we need them to pursue the popular agenda of the people they represent, even if not one they hold with conviction themselves. But under our current structure your leadership is actually more responsible to the people who put them there, the Nominating Committee, than to the membership at large. This is something we need to change for our long-term vitality. Now don't get me wrong, by and large, nominating committees have provided this and other societies with outstanding leaders over the years, frequently advancing those on the Executive Committee who have shown initiative and leadership. This provides continuity of leadership that has many positive attributes. Furthermore, traditional nominating committees, typically composed of a variable number of past presidents, are well-positioned to observe and recognize talent. But the very process is corrupting to a democratic system. The process creates stagnation in leadership, because those aspiring to such positions tend to endorse and promote the opinions of those who will be on the Nominating Committee of their future. Please don't misinterpret my words here. I am *not* implying that the people themselves are in any way corrupt. Your leaders have championed causes for vascular surgery that they were convinced were best for us, and their conviction was frequently supported by others in leadership positions around them. The problem is that the current system typically creates a homogeneous leadership group, one pre-selected for agreement on key critical issues, and largely precludes true electoral choice for the membership.

I can come up with no more poignant example for you than myself, your current president. I stand before you your elected president. But did any of you really vote for me? Not really; you essentially just endorsed the selection of the Nominating Committee. And while nominating committees often have great insight, and I certainly hope that you view me as a good choice, the fact is that some of you probably didn't even vote at all, some voted for me with conviction, and others voted for me simply because that's the way it has always been done. I cannot think of a better example of disenfranchisement than voting for something simply because it is the way it has always been done. Nor can I think of a better example of how our governance structure has not kept pace with changing times.

At yesterday's executive council meeting your council unanimously supported my proposal that the Constitution and Bylaws Committee consider changes in our governance that would open up our electoral process and welcome more active participation of the membership. While I believe that the traditional nominating committee structure and process is valuable, I simply believe that there has to be a respectable way for alternative direction to be pursued by our members if and when they deem it necessary. The model I have proposed would allow any member in good standing to have his or her name placed in nomination for any available position on receipt of a petition signed by 10% of the active membership at least 90 days before the annual meeting. The Nominating Committee would be charged with advancing its recommendations within a similar time frame, and any and all candidates would be asked to produce a summary of their accomplishments and philosophies, which would be distributed to the membership well before the annual meeting. There would be no need for the secrecy that presently surrounds the nominating process, and our membership would truly have the opportunity for input into the direction of our society. Your Constitution and Bylaws Committee will be considering this and other possible alternative nominating structures over the next year, and I expect we should be able to have other electoral models before you for your consideration by next year's meeting.

THE BIGGER PICTURE

So far my comments have related to how we as vascular surgeons govern ourselves. But no discussion of governance would be complete without consideration of the way we relate to the ABS. Nor could it be more timely inasmuch as a new training initiative is before us, one that could have ramifications for our pursuit of an independent ABVS. By now you are all likely aware of the sudden and unanimous willingness of the ABS to recognize the discipline of vascular surgery as unique, not by granting us our long-sought independence, but by establishing a primary certificate in vascular surgery under the ABS. This would allow us to totally revamp our training paradigm, likely to a 3-plus-3 program similar to that suggested by Dr Ascher last year.[2] While no reasonable person would argue against that specific accomplishment, the plan has received mixed reviews because of what we are not being told about it, that being it's effect on our pursuit of an independent ABVS and the fact that we would still be governed by general surgery. In fact, Frank Lewis confirmed our worse fears in a recent meeting with Jim Stanley and others when he noted that "actions of the VSB would still be subject to full ABS Board approval, and not all vascular initiatives would be favorably reviewed."[5] So while the opportunity to revamp our training paradigm is enticing, make no mistake about it, this accomplishment comes with a price tag attached.

The SVS has asked for input into this issue from all of the national and regional vascular surgery societies. The executive council of the Eastern Vascular Society met on February 21, 2004. It was reported that the consensus of the majority was that "the application for a primary certificate in vascular surgery only be pursued if it is considered as a waystation to complete independence from the ABS within a finite period of time."[6] Your Executive Council took up the issue at our meeting yesterday, and by secret ballot a clear majority voted to adopt the same position as had the Eastern Vascular Society. But there was uneasiness about this action for myself and others, because it is indeed a critical juncture in our journey. So while we were happy to voice our collective executive council opinion, we also believe that ideally we should fully enlighten all members of the vascular surgery community of the details of the proposal and any of its ramifications, and then let the membership's voice be heard. You may recall that several years ago a number of polls were taken, all of which were solidly in favor of the pursuit of independence, especially among the youth of our specialty, whose future is most at stake. It only seems reasonable that if we took a vote to plot this course of action in the first place, we should take a vote for any major change of course. Yesterday your council voted to encourage the ABVS to do just that, and pledged financial support to help make that poll happen.

My perspective on the primary certificate issue, since you asked, is that it is less of a concession from the ABS than it is a political strategy on their part to undermine our movement for independence once and for all. That being said, the primary certificate offer on the table does provide us the much needed opportunity to change our training paradigm at a time when that is desperately needed, and so will have appeal to some. I believe that the most important thing is that vascular surgeons rally together around the will of the majority, and I personally pledge to do just that. But for any of us to make a legitimate assessment of the situation requires candid objective information about the effect of this proposal on our pursuit of independence, information that has not been forthcoming.

Absent such information, I and others have concluded that accepting this primary certificate will make it significantly more difficult, if not absolutely impossible, to continue on to independence, because of the rules and policies in existence within the Accreditation Council for Graduate Medical Education and related agencies. Therefore I personally oppose this initiative without written assurances from the ABS that this would be a waystation to complete independence within a reasonable and finite period of time. While the primary certificate itself is a good thing, the maintained control over vascular surgery by general surgery perverts the natural process of maturation that all bona fide specialties undergo. Our specialty has evolved to the point where even the ABS is willing to recognize it as a distinct specialty, as evidenced by their willingness to pursue a primary certificate in vascular surgery. So stopping short of offering us full independence is clearly more about maintaining dominance and control over us than it is about our qualifications for that status. And that maintained dominance has many more ramifications than I have time to go into today, but that are well delineated in the recent newsletter of the ABVS, which I highly recommend you read. I am reminded of a talk Dick Green once gave aimed at explaining to radiologists why vascular surgeons wanted to be doing endovascular procedures. I had given a number of such talks over the years, typically puffing out my chest and declaring my right to provide these services to my patients, but Dick's talk was different. Using the Shel Silverstein story of "The Missing Piece" as an analogy, he explained that vascular surgeons would be involved in endovascular therapies because they were a fit for us that made us whole. I can think of no better message about out pursuit of independence to send to the ABS than that. These are unstoppable human aspirations, aspirations for independence, self-determination, and recognition of one's distinction. They are what make us whole, and they will not go away. It is for that very reason that I believe we will have continued conflict and strife within our ranks, and with the ABS, until complete independence is achieved.

Now, some would say that I am just jaded by the behaviors of the "old" ABS, that this is a different group now, prepared to treat us differently. But let us not forget that today's "new" ABS will be tomorrow's old ABS the next time the need for change in our discipline threatens general surgery. In fact, an example has already emerged. Part of the primary certificate proposal includes expanded representation on the Vascular Surgery Board of the ABS, including a new representative from this organization. You would like to think that we would get to choose our

representative, and in fact we do, kind of. The traditional ABS approach is to request 3 names from us to represent us, from which they choose who they want to work with, presumably the person they feel is most aligned with their priorities and not necessarily the one most aligned with ours. This policy, a relic of the past, is simply not how you treat colleagues, but how you treat subjects. Would it were that the ABS would see the long-term wisdom in partnering with us as equal colleagues to try to solve our respective training problems collegially. Would that they could see that they are only forestalling the inevitable, and that all concerned would be best off to get on with our respective new paradigms.

MOVING ON

As is typically the case, presidents more often only get to propose or initiate change than to actually see it come about. Nonetheless, I trust those who follow in my footsteps will see similar value in the initiatives I have laid out here today, and will work to make them happen. I trust that you, too, will see value in them, and demand that they happen. While in my opinion these initiatives represent nothing more than the right way to do business, others have found them unreasonable, which brings me to a closing quote from George Bernard Shaw:

"The reasonable man adapts himself to the world. The unreasonable one persists in trying to adapt the world to himself. Therefore, all progress depends on the unreasonable man." Vascular surgery could use a few more unreasonable men and women.

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